Appendix F.4

Health Care Plan Period _____ to _____ Review date _____	INDIVIDUALIZED HEALTH **CARE ACTION PLAN**

I. IDENTIFYING INFORMATION	
Student's name	School
Birthdate	Teacher
Age	Grade

CONTACTS

PARENT/GUARDIAN
Mother's name _____ Home Phone_____

Address _____Work Phone _____

Father's name _____Home Phone _____

Address _____ Work Phone _____

PHYSICIAN
Physician _____Phone _____

Address _____
HOSPITAL
Hospital Emergency Room _____Phone _____

Hospital Address _____Phone _____

EMERGENCY MEDICAL SERVICES _____

II. MEDICAL OVERVIEW

Medical condition _____Any Known Allergies _____

Medications _____

Possible side effects _____

Health care procedures needed at school

III. OTHER SIGNIFICANT INFORMATION
☐ Emergency Action Plan on file ☐ Individual Health Plan on file
IV. BACKGROUND INFORMATION/NURSING ASSESSMENT
Brief Medical History
Special Health Care Needs
Social/Emotional Concerns
V. HEALTH CARE ACTION PLAN
Attach physician's order and any specialized procedure.
Student specific procedures/interventions

Procedure	Performed by	Equipment	Maintained by	Authorized/trained by

V. HEALTH CARE ACTION PLAN (cont.)		
Medications		
Dietary Needs		
Transportation Needs		
Classroom/School Modifications (including adaptive PE)		
Equipment – list necessary equipment/supplies	Provided by parent	Provided by school
None required		
Safety measures		
Substitute/Back up (when primary caregiver is not available)		
Possible problems to be expected when performing procedure(s)		
Emergency Plan _____ Transportation Plan _____		

VI. DOCUMENTATION OF PARTICIPATION

We have participated in the development of the Health Care Action Plan and agree with its contents.

Signature_____ Date _____

_____ Administrator or Designee

_____ Parent

_____ Nurse

_____ Teacher

_____

_____

VI. PARENT AUTHORIZATION FOR SPECIAL HEALTH SERVICES

We (I), the undersigned who are the parents/guardian of _____
Birthdate _____, request and approved this Health Care Action Plan. We (I), understand that a qualified person(s) will be performing the health care service. It is our understanding that in performing this service, the designated person(s) will be using the attached special care procedure which has been approved by the student's physician and health care team.

We (I) will notify the school immediately if the health status of _____
changes, if we change physicians, or there is a change or cancellation of the procedure.

We (I) agree to provide the following, if any: medication, medication equipment and supplies and dietary supplements requiring a prescription.

_____ Parent Signature Date _____	_____ Parent Signature Date _____